Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Payers Differ on Facility Charges for Multiple Imaging Services

You shouldn't have trouble with the professional component, but be careful with TC

Question: When we perform a chest CT scan (71260) on a trauma patient, we also reformat the data into a spine exam (codes 72129 or 72132). Therefore, we have a report for the CT chest and a separate report for the CT spine. The code for two-dimensional reformatting is no longer separately reportable, so we charge the patient for both the CT chest and CT spine. What is the proper way to report and charge for this type of exam since we perform both using one acquisition?

Answer: You can report the physician's portion, but the facility charge might be a little bit stickier.

For the physician's professional service, the Spring 2006 issue of the AMA's Clinical Examples in Radiology says that you can appropriately report the spine CT code when the radiologist does a full and complete spine interpretation, says **Jackie Miller, RHIA, CPC**, with **Coding Strategies Inc.**

The article notes, -If a full and complete spine interpretation is requested subsequently from reconstructed data (e.g., from the trauma series performed for abdomen evaluation), it is appropriate to code for the additional professional services by reporting the appropriate 70000 series CT CPT code(s) appended by modifier 26.-

The problem, Miller says, is the facility charge. -Everyone agrees that it is not appropriate for the facility to receive full payment for two CT scans when there was only one image acquisition. However, that's about as far as the agreement goes.-

The American Hospital Association's Third Quarter 2006 Coding Clinic for HCPCS states, -Although the images were reconstructed to show images of the lumbar spine, an additional code for the reconstructed image of the lumbar spine is not required since this did not require a rescanning of the patient.-

Therefore, some payers may follow that advice and not reimburse the facility for the spine exam, while others might be more flexible.

-I think it's reasonable for the hospital to want some reimbursement for the work involved in the spine exam,- Miller says. -Clinical Examples in Radiology recommends the use of modifier 52 (Reduced services) on the technical component charge, and I think this is a reasonable solution.-

Providers should watch their payer policies closely because some carriers are just discovering this quandary and may soon be writing up and implementing guidelines about it, Miller cautions.